Unannounced Care Inspection Report
19 May 2016

Glendun

Address: 67 Knocknacarry Road Cushendun BT44 0NS
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Inspector: Lyn Buckley

1.0 Summary

An unannounced inspection of Glendun took place on 19 May 2016 from 09:45 to 16:15 hours.

The inspection sought to assess progress with issues raised during and since the previous inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

There was evidenced of competent delivery of care with positive outcomes for patients.

Review of records evidenced that planned staffing levels were adhered to; and discussion with patients, representatives and staff evidenced that there were no concerns regarding staffing levels. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty.

The registered manager and staff spoken with demonstrated the knowledge, skill and experience necessary to fulfil their role, function and responsibilities in general and specifically in relation to adult safeguarding. Staff described their role and responsibilities with enthusiasm and said that they were enabled to 'make a difference'.

Fire exits and corridors were observed to be clear of clutter and obstruction. Infection prevention and control measures were adhered to and equipment was appropriately stored.

There were no areas for improvement identified.

Is care effective?

It was evident that care was effectively managed and delivered with positive outcomes for patients. For example, Care records accurately reflected the assessed needs of patients, were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians. Registered nurses assessed, planned, evaluated and reviewed care in accordance with NMC guidelines.

Observations evidenced that call bells were answered promptly and patients requesting assistance in one of the lounge areas or the dining room were responded to in a calm, quiet and caring manner. All patients and relatives spoken commented positively regarding the care they received and the staffs caring and kind "nothing is any trouble" attitude.

Staff stated that there was "effective teamwork"; this was also evidenced through discussion and observation of interactions throughout the inspection process. Staff stated they were "proud" to be a part of their team and to "make a difference

There were no areas for improvement identified.

Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. Staff were also aware of the requirements regarding patient information, confidentiality and issues relating to consent.

Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

There was evidence of a high standard of compassionate care in relation to making patients and their visitors, encouraging the local community to come into the home so patients can participate in community events; and in working with patients to make improvements in the home.

There were no areas for improvement identified.

Is the service well led?

There was clear evidence that system and process were in place and effectively managed to ensure the safe, effective, and compassionate care was delivered by a competent and caring team of staff. For example, staff were knowledgeable of the complaints and adult safeguarding processes commensurate with their role and function. A review of notifications of incidents to RQIA during the previous inspection year/or since the last care inspection confirmed that these were managed appropriately. Discussion with the registered manager and review of records evidenced that systems were in place to ensure that notifiable events, complaints, and/or potential adult safeguarding concerns were investigated and reported to RQIA or other relevant bodies appropriately.

There were no areas for improvement identified.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	0

This inspection resulted in no requirements or recommendations being made. Findings of the inspection were discussed with Mrs, Clare Burke, registered manager, and Mr David Leo Morgan, registered person, as part of the inspection process and can be found in the main body of the report.

Enforcement action did not result from the findings of this inspection.

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an announced estates inspection on 24 November 2015. Other than those actions detailed in the previous QIP there were no further actions required. Enforcement action did not result from the findings of this inspection.

RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI's), potential adult safeguarding issues, whistle blowing and any other communication received since the previous care inspection.

2.0 Service details

Registered organisation/registered person: Glendun Nursing Home Ltd/ Mr David Leo Morgan	**Registered manager:** Mrs Clare Burke
Person in charge of the home at the time of inspection: Mrs Clare Burke	**Date manager registered:** 4 June 2015
Categories of care: NH I, NH-PH, RC-I, RC-LD, RC-MP(E), RC-PH(E) and RC-DE A maximum of 20 residential beds with a maximum of 5 residents in category RC-DE within this. Category RC-LD for one identified person.	**Number of registered places:** 46

3.0 Methods/processes

Prior to inspection we analysed the following information:

- notifiable events since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned quality improvement plan (QIP) from the previous care inspection
- the previous care inspection report.

During the inspection the inspector spoke with nine patients and greeted others in small groups, nine care staff, one registered nurse, two catering staff, two staff from housekeeping, two relatives, the administrator and one of the painters in to redecorate the main lounge.

The following information was examined during the inspection:

- three patient care records
- staff roster 9 - 22 May 2016
- staff training and planner/matrix for 2015 and 2016
- one staff recruitment record
- complaints record
- incident and accident records
- record of quality monitoring visits carried out in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005
- records of audit/governance
- staff appraisal and supervision planners 2015/16
- records pertaining to consultation with staff, patients and relatives.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 24 November 2015.

The most recent inspection of the home was an announced estates inspection. The completed QIP was returned and approved by the estates inspector.

Areas to follow up during this inspection were agreed between the care and estates inspectors as follows:

a. the progress in relation to relocating the smoke room
b. staff participation in fire drills.

Patients consulted and records confirmed that a meeting had been held with patients to discuss options for the relocation of the smoking room. Agreement was reached and a new smoke area established in the courtyard. The 'old' smoke lounge will be refurbished and provide additional lounge space for patients.

Review of mandatory training matrix for 2016 evidenced that the registered manager had added 'fire drill/evacuation' as part of the matrix. Records indicated that, so far this year, the majority of staff had participated.

There were no requirements or recommendations made in relation to the areas followed up.

4.2 Review of requirements and recommendations from the last care inspection dated 16 November 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 15(1)(e) **Stated:** First time	It is required that the registered persons ensure that the nursing home does not provide accommodation for any persons outside of the registered categories of care.	**Met**
	Action taken as confirmed during the inspection: An application to vary registration was received at end of November 2016; and approved in December 2015. Observation and discussion with the registered persons confirmed that categories of care were adhered to. This requirement has been met.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 36 **Stated:** First time	It is recommended that staff should be aware of the content of revised policies/procedures, including the relevant regional guidance which underpins care delivery, commensurate with their role and function.	**Met**
	Action taken as confirmed during the inspection: Review of records, discussion with staff and discussion with the registered manager confirmed that this recommendation had been met.	
Recommendation 2 **Ref**: Standard 37 **Stated:** First time	It is recommended that patient records are maintained contemporaneously and therefore accurate in relation to the delivery of care and that records are held confidentially to maintain the patient's right to privacy.	
	Action taken as confirmed during the inspection: Discussion with staff and review of records confirmed that this recommendation had been met.	**Met**
Recommendation 3 **Ref**: Standard 41 **Stated:** First time	It is recommended that the registered manger's hours are recorded in advance and that the registered manager's hours worked as a nurse in charge of the a shift are clearly recorded against the hours worked supernumerary.	**Met**
	Action taken as confirmed during the inspection: Review of duty rotas and discussion with the registered manager confirmed that this recommendation had been met.	

4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota from 9 – 22 May 2016 evidenced that the planned staffing levels were adhered to. Discussion with patients, representatives and staff evidenced that there were no concerns regarding staffing levels. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty.

Discussion with staff and review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. New staff were supported through their induction by a dedicated mentor. Review of one staff member's induction evidenced the record to be completed in full and signed/dated appropriately.

Review of the training planner/matrix for 2016 indicated that training was planned to ensure that mandatory training requirements were met. Staff confirmed that they were required to attend mandatory training and would be 'put of the rota' if they failed to attend without a valid reason. The records reviewed confirmed that the majority of staff had, so far this year, completed training in fire safety and evacuations, adult safeguarding, moving and handling and some staff had completed first aid training. Review of training completed in 2015 indicated that mandatory training requirements had been met by the majority of staff.

A planner was in place to manage staff supervision sessions and appraisals. On the day of inspection a group supervision session had been arranged for seven care staff and one of the areas on the agenda was the modifying/thickening of fluids. The session was conducted by the registered manager and included a practical and tasting session. Staff confirmed that they had enjoyed the sessions and that they appreciated the difficulties patients faced when their food and fluids required to be modified or thickened.

The registered manager and staff spoken with demonstrated the knowledge, skill and experience necessary to fulfil their role, function and responsibilities in general and specifically in relation to adult safeguarding. Staff described their role and responsibilities with enthusiasm and said that they were enabled to 'make a difference'.

Discussion with the registered manager and review of records evidenced that the arrangements for monitoring the registration status of nursing and care staff was appropriately managed in accordance with Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC).

Review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since June 2015 confirmed that these were managed appropriately. Audits of falls and incidents were maintained and clearly evidenced analysis of the data to identify any emerging patterns or trends and action plans were in place as required. This information also informed the responsible individual's monthly monitoring visit in accordance with Regulation 29.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounge/s, dining rooms and storage areas. The home was found to be warm, well decorated, fresh smelling and clean throughout. Housekeeping staff were commended for their efforts. The main lounge area on the ground floor was being painted on the day of inspection. A new floor had also been fitted to the whole of the ground floor and light levels increased to enable patients and staff to move around the home with ease. Housekeeping staff said that the new flooring was easier to clean and the light/natural colour added to the overall 'brightness' of the environment. Patients, representatives and staff spoken with were complimentary in respect of the home's environment and the improvements made to date and planned for the future. Patients were looking forward to the completion of the redecorating in the main lounge; some of the ladies said they already knew where they were going to sit in the 'new' lounge.

Fire exits and corridors were observed to be clear of clutter and obstruction. Infection prevention and control measures were adhered to and equipment was appropriately stored.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	**0**	**Number of recommendations**:	**0**

4.4 Is care effective?

Review of patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. Risk assessments informed the care planning process and both were reviewed as required. For example, records in relation to the management of falls indicated that when a patient sustained a fall the risk assessment and care plan were reviewed to ensure they continued to be relevant. This is good practice.

Care records accurately reflected the assessed needs of patients, were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians. Registered nurses assessed, planned, evaluated and reviewed care in accordance with NMC guidelines.

There was evidence that the care planning process included input from patients and/or their representatives, if appropriate. There was evidence of regular communication with representatives within the care records.

Supplementary records such as repositioning/food and fluid intake records evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements. Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records.

Observations evidenced that call bells were answered promptly and patients requesting assistance in one of the lounge areas or the dining room were responded to in a calm, quiet and caring manner. All patients and relatives spoken commented positively regarding the care they received and the staffs caring and kind "nothing is any trouble" attitude.

Staff confirmed that they were kept informed of changes or concerns regarding patients' needs through the handover reports at the beginning of their shift. Staff also confirmed that regular staff meetings were held, that they contributed to the agenda and that minutes were made available. The last general staff meeting was held on 30 October 2016, and a nurse and senior carer meeting held on 2 March 2016. Minutes were available.

Staff stated that there was "effective teamwork"; this was also evidenced through discussion and observation of interactions throughout the inspection process. Staff stated they were "proud" to be a part of their team and to "make a difference". Each staff member knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with their line manager, the registered manager, and/or the registered person David Morgan. All grades of staff consulted clearly demonstrated the ability to communicate effectively with the patients, with their colleagues and with other healthcare professionals.

Some staff raised concerns such as appreciation of their work from line managers, being listened to in relation to employment matters and access to the registered manager for one to one discussion. However, staff reiterated that they enjoyed their work and felt that Glendun was "like a family and provided excellent care". This was discussed with the registered persons during feedback.

Communication with patients and their representatives was evident on a one to one basis as recorded in the care records and through observations of interactions. Patients confirmed that both the registered manager and registered person were available to them on a daily basis. One patient said, "David and Clare – yes I know they are the management but you can't tell – they are so good to me and they don't keep saying what they are; they deliver". The patient went on to describe many examples of "going the extra mile" they had experienced.

Discussion with relatives confirmed that they were kept informed of any changes in their loved ones health and wellbeing and stated that they felt assured that the care was effective, caring, loving and kind. Relatives confirmed that they could ask David and Clare or any of the staff about anything and were confident it would be "attended to". In addition to the day to day communication with patients and their representatives, management used the invoicing system to send information to representatives/families. For example, when the invoices for each month were prepared, details of the consultation process for moving the smoke room and the decision reached would be attached or information about forthcoming events in the home. This is good practice.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	**0**	**Number of recommendations**:	**0**

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. Staff were also aware of the requirements regarding patient information, confidentiality and issues relating to consent.

Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

As stated previously in section 4.4, patients confirmed that both the registered manager and registered person were available to them on a daily basis. One patient said, "David and Clare – yes I know they are the management but you can't tell – they are so good to me and they don't keep saying what they are; they deliver". The patient went on to describe many examples of "going the extra mile" they had experienced. Other patients described how staff supported them "over and above the call of duty" on a daily basis. Another patient described how staff would bring a tray of tea and biscuits to their room when they had visitors. The patient said that they rarely had to ask for this to happen as the staff anticipated his needs. The patient said it was just like at home and felt "more normal" because of it. Discussion with catering and other staff confirmed that the offering/delivering of a tray of tea/coffee and biscuits was "normal practice". One staff said "this is their home; they can't make the tea so we do it for them". Other staff described this practice as normal day to day activity and thought it "odd" that not all homes would do this.

In addition to the provision of tea and coffee for patients' visitors, the inspector observed a number of very personal touches within patients' bedrooms which were small gestures on the part of staff but would have added greatly to the patient's comfort and reassurance. This was commended during feedback.

Patients also said that they enjoyed activities in the home and described how the local Parish held 'whist' nights every month in the dining room and that the home took their turn to host the Parish meeting. Both enabled patients to attend and participate. This was also commended during feedback.

Patients also commented positively in relation to the standard of food. Patients confirmed that they enjoyed going to the dining room but could also arrange to have their meal in the lounge or their bedroom. One patient said the choice was "endless" explaining further that while there was a menu you could ask for anything and if the kitchen had it you would get it. Another patient commended highly the breakfast they had enjoyed that morning. Catering staff were clear that the dining experience and eating was a social and pleasurable experience and that they endeavoured to achieve this for each meal. Recently patients and staff had met to discuss the lunch time meal and they had decided to trial a lighter lunch with the main meal at tea time. The chef and patients confirmed that this, so far, seemed to be well received but as it was only week two of the trial they would keep going and review it later. This was commended.

Observation of one staff member interaction with a patient during the serving of the mid-morning tea and snack was commended. The care assistant said gently and quietly "here….taste this first" while offering the snack. Eventually the patient ate the snack offered and drank their tea. When asked about this observation the care assistant explained that the patient always ate well if they tasted the food first – so they would always use that approach to 'coax them' making sure they got their nutrition. This was one example of how well staff knew patient individual needs and preferences.

Patient confirmed that there were arrangements were in place to meet their religious and spiritual needs within the home.

Patients also had access to the internet and digital television channels.

Discussion with the registered manager confirmed that the views of patients, their representatives and staff on the running of the home were sought on a daily basis and through meeting as discussed previously. On an annual basis formal questionnaires were distributed Views and comments recorded were analysed and an action plan was developed and shared with staff, patients and representatives. This formal process was, at the time of the inspection, nearing conclusion.

Comments made to the inspector, other than those detailed previously, included;

“”I am very content – the girls are great.”
“Clare and David never stop.”
“I am well looked after and I feel safe and well care for.”
“David is very generous with his time….”
“I have no complaints but have confidence that management would address them.”

As part of the consultation process the inspector asked the home to distribute questionnaires. Ten questionnaires were provided for staff and patient representative/relative and eight for patients. At the time of issuing this report none had been returned within the specified timeframe. Review of returned questionnaires will be dealt with under separate cover as required.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	**0**	**Number of recommendations**:	**0**

4.6 Is the service well led?

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff were able to describe their roles and responsibilities. In discussion patients were aware of the roles of the staff in the home and whom they should speak to if they had a concern. Staff were able to identify the person in charge of the home.

The registration certificate was up to date and displayed appropriately. A valid certificate of public liability insurance was current and displayed.

Discussion with the registered manager and observations evidenced that the home was operating within its registered categories of care.

Policies and procedures were indexed, dated and approved by the registered person. Staff confirmed that they had access to the home’s policies and procedures and were expected to read and record that they had read various policies.

Discussion with the registered manager and review of the home’s complaints record evidenced that complaints were managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015. Patients and representatives spoken with confirmed that they were aware of the home’s complaints procedure. Patients/representatives confirmed that they were confident that staff/management would manage any concern raised by them appropriately.

Staff were knowledgeable of the complaints and adult safeguarding process commensurate with their role and function. A review of notifications of incidents to RQIA during the previous inspection year/or since the last care inspection confirmed that these were managed appropriately. Discussion with the registered manager and review of records evidenced that systems were in place to ensure that notifiable events, complaints, and/or potential adult safeguarding concerns were investigated and reported to RQIA or other relevant bodies appropriately.

Discussion with the registered manager and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, audits were completed in accordance with best practice guidance in relation to falls, care records, infection prevention and control, environment, complaints, incidents/accidents. Record also evidenced that the results of audits had been analysed and appropriate actions taken to address any shortfalls identified and there was evidence that the necessary improvements had been embedded into practice.

There was an effective system in place to ensure nursing staff were registered with the nursing and Midwifery Council; and that care staff were registered with the Northern Ireland Social Care Council (NISCC). New care staff not registered with NISCC were required and supported to register.

Review of reports and discussion with the registered manager evidenced that Regulation 29 monitoring visits were completed in accordance with the regulations and/or care standards. An action plan was generated to address any areas for improvement. Copies of the reports were available for patients, their representatives, staff and Trust representatives.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	**0**	**Number of recommendations**:	**0**

5.0 Quality improvement plan

No requirements or recommendations resulted from this inspection.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the registered person/manager from their responsibility for maintaining compliance with the regulations and standards.

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